TITLE 20: CORRECTIONS, CRIMINAL JUSTICE AND LAW ENFORCEMENT
CHAPTER VII: SEX OFFENDER MANAGEMENT BOARD

PART 1905
INTERIM SEX OFFENDER EVALUATION AND TREATMENT

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AUTHORITY: Authorized by Sec. 15 of the Sex Offender Management Board Act ("Act") [20 ILCS 4026/15] and implementing Sections 15 – 18 of that Act; Sections 5-701 and 5-715(3.10) of the Juvenile Court Act of 1987 [705 ILCS 405/5-701 and 5-715(3.10)]; Section 8 of the Sexually Dangerous Persons Act [725 ILCS 205/8]; Sections 10(c)(2), 25(e), 30(c), 40(b)(1), 55(b), 60(c), and 65(a)(2) and (b)(2) of the Sexually Violent Persons Commitment Act [725 ILCS 207/10(c)(2), 25(e), 30(c), 40(b)(1), 55(b), 60(c), and 65(a)(2) and (b)(2)]; and Sections 3-3-7(a)(7.5), 3-6-2(j) and (k), 3-9-7(b), 5-3-2(b-5), 5-6-3(a)(8.5) and 5-7-1(f-5) of the Unified Code of Corrections [730 ILCS 5/3-3-7(a)(7.5), 3-6-2(j) and (k), 3-9-7(b), 5-3-2(b-5), 5-6-3(a)(8.5) and 5-7-1(f-5)].

SOURCE: Emergency rules adopted at 28 Ill. Reg. _____, effective May , 2004, for a maximum of 150 days.

Section 1905.10 Purpose and Scope
EMERGENCY

Effective January 1, 2004, the Sex Offender Management Board Act ("Act") [20 ILCS 4026] and various other statutes provide for the evaluation and/or treatment of convicted sex offenders in conformance with standards adopted by, and by persons approved by, the Sex Offender Management Board. This Part establishes requirements for evaluators and treatment providers to obtain Board approval to perform those functions through July 1, 2005. It also establishes standards for conducting evaluations of, and providing treatment to, sex offenders in all circumstances where conformance with Board standards is required through July 1, 2005.

Section 1905.20 Definitions
EMERGENCY

In this Part, the terms "Board," "sex offender," "sex offense," "management," and "sexually motivated" have the meanings ascribed to them in Sec. 10 of the Act. In addition, the following definitions apply:

"Accountability": Accurate attributions of responsibility, without distortion, minimization, or denial.

"Behavioral Monitoring" includes a variety of methods for checking, regulating, and supervising the behavior of sex offenders.

"Case Management" means the coordination and implementation of the cluster of activities directed toward supervising, treating, and managing the behavior of individual sex offenders. (See Containment Approach)

"Containment Approach" is a method of case management and treatment that seeks to hold offenders accountable through the combined use of both offenders' internal controls and external control measures (such as the use of polygraph and relapse prevention plans). A containment approach requires the integration of a collection of attitudes, expectations, laws, policies, procedures, and practices that have clearly been designed to work together. This approach is implemented through interagency and interdisciplinary teamwork.

"Containment Team" is a group comprising, at a minimum, a sex offender's supervising officer, and treatment provider and utilizing the containment approach. Team members may change over time as issues develop regarding treatment and supervision.

"Defense Mechanisms" means normal, adaptive, self-protective functions which keep human beings from feeling overwhelmed and/or becoming psychotic, but which become dysfunctional when overused or overgeneralized.

"Denial," as used in Subpart D of this Part, is a defense mechanism used to protect the ego from anxiety-producing information.

"Evaluation" means the systematic collection and analysis of psychological, behavioral, and social information; the process by which information is gathered, analyzed, and documented.

"Experience" includes any activity directly related to providing evaluation and/or treatment to individual sex offenders, e.g., face-to-face therapy, report writing, administration, scoring, and interpretation of tests; participation on containment teams of the type described in these standards and guidelines; and clinical

supervision of therapists treating sex offenders.

"Informed Assent" means compliance; a declaration of willingness to do something in compliance with a request; acquiescence; agreement. The use of the term "assent" rather than "consent" in this document recognizes that sex offenders are not voluntary clients, and that their choices are therefore more limited. Informed means that a person's assent is based on a full disclosure of the facts needed to make the decision intelligently, e.g., knowledge of risks involved, alternatives.

"Informed Consent": "Consent" means voluntary agreement, or approval to do something in compliance with a request. "Informed" means that a person's consent is based on a full disclosure of the facts needed to make the decision intelligently, e.g., knowledge of risks involved, alternatives.

"Non-Deceptive Polygraph Examination Result": A non-deceptive polygraph examination result must include a deceptive response to control questions. Any inconclusive or deceptive response to any relevant question disallows a non-deceptive examination result.

"Parole" refers to parole or mandatory supervised release.

"Polygraph": The employment of instrumentation, as defined by the Illinois Detection of Deception Examiners Act [225 ILCS 430], used for the purpose of detecting deception or verifying truth of statements of a person under criminal justice supervision and/or treatment for the commission of sex offenses. A clinical polygraph examination is specifically intended to assist in the treatment and supervision of convicted sex offenders. Clinical polygraphs include specific-issue, disclosure and periodic or maintenance examinations. Clinical polygraphs may also be referred to as post-conviction polygraphs.

"Professional license" means a license issued by a State governmental body to practice a particular health or mental health profession.

"Sex offense specific" means relating to the problem of sexual offense behavior.

"Sexually violent person" has the meaning given to it in Sec. 5 of the Sexually Violent Persons Commitment Act [725 ILCS 207/5].

"Supervising Officer": The probation or parole officers are responsible for the behavioral monitoring of sex offenders. In addition, any person employed by the Department of Human Services or by an entity that contracted with the Department of Human Services to supervise sexually violent persons on conditional release.

"SVP" means sexually violent person or persons, depending on the context.

"Treatment" means therapy, monitoring and supervision of a sex offender.

Section 1905.30 Interim Provider List
EMERGENCY

The Board will establish an interim approved provider list upon which will be placed the names of all individuals who are approved by the Board to provide evaluations and treatment of sex offenders through July 1, 2005, along with the category of the services the providers are approved to provide (e.g., pre-sentence or pre-release evaluations). Providers will be placed on the list if they complete the application process described in Sec. 1905.100, meet the general requirements of Sec. 1905.40, and meet the specific qualifications and requirements that correspond to the designation sought.

a) Individuals who meet the qualifications of Sec. 1905.50 will be approved for conducting pre-sentencing evaluations to meet the requirements for evaluations of:

1) felony sex offenders who are to be considered for probation, pursuant to Sec. 16(b) of the Act (adult or juvenile),

2) any adult before sentencing on a felony sex offense or any felony offense that is sexually motivated, pursuant to 730 ILCS 5/5-3-2(b-5) and 5-3-1, and

3) a minor found guilty of a sex offense, pursuant to 705 ILCS 405/5-701.

b) Individuals who meet the qualifications of Sec. 1905.60 will be approved for conducting evaluations to meet the requirements for evaluations of:

1) every person convicted of a sex offense, prior to release into the community from the Department of Corrections, pursuant to 730 ILCS 5/5-4-1(e)(3.5);

2) any person as required in the Sexually Violent Persons Commitment Act [725 ILCS 207/5].

c) Individuals who meet the qualifications of Sec. 1905.70 will be approved to provide sex offender treatment to any person, adult or juvenile, who is required to undergo treatment from a provider approved by the Board.

d) An individual who is approved to conduct pre-sentencing evaluations under subsection (a) above is also approved to conduct the evaluations listed under subsection (b) above.

Section 1905.40 General Requirements for Approval of Evaluators and Providers EMERGENCY

a) Sex offender evaluators and treatment providers will not be eligible for Board approval if they have ever:

1) been convicted of any felony;

2) been convicted of any misdemeanor involving a sex offense;

3) had a professional license placed on inactive status, suspended, revoked, non-renewed, or placed on probationary status for disciplinary reasons unless the applicant has been restored to full practice rights;

4) been found by any licensing body to have engaged in unethical or unprofessional conduct unless the applicant has been restored to full practice rights; or

5) been engaged in deceit or fraud in connection with the delivery of services, supervision, or the documentation of their credentials.

b) A provider must continue to maintain eligibility under this Section in order to remain on the approved provider list and has a continuing duty to notify the Board should he or she ever become disqualified under this Section.

Section 1905.50 Interim Qualifications for Provision of Evaluations Before Sentencing EMERGENCY

In order to be approved to provide pre-sentence evaluations as described in Section 1905.30(a), an applicant must:

a) hold a bachelor's degree or higher in a behavioral science;

b) have 400 hours of supervised experience in the treatment/evaluation of sexual offenders in the last 4 years, at least 200 of which are face-to-face therapy/evaluation with sexual offenders;

c) have completed at least 10 sex offender evaluations under supervision in the past 4 years; and

d) have at least 40 hours of documented training in the specialty of sex offender evaluation/treatment/management.

Section 1905.60 Interim Qualifications for Provision of Pre-release and SVP Evaluations EMERGENCY

In order to be approved to provide pre-release and SVP evaluations as described in Section 1905.30(b), an applicant must:

a) hold a bachelor's degree or higher in a behavioral science,

b) have 400 hours experience with forensic clients within the past 4 years, and

c) have at least 20 hours of documented training in the specialty of sex offender evaluation/treatment/management or will work under the supervision of a provider who has undergone 40 hours of documented training and 400 hours experience in sexual offender evaluation/treatment/management.

Section 1905.70 Interim Qualifications for Treatment Providers
EMERGENCY

In order to be approved to provide sex offender treatment, an applicant must:

a) hold a bachelor's degree or higher in a behavioral science;

b) have 400 hours of supervised experience in the treatment of sexual offenders in the last 4 years, at least 200 of which are face-to-face therapy with sexual offenders; and

c) have at least 40 hours documented training in the specialty of sex offender assessment/treatment/management.

Section 1905.80 Supervision by Approved Providers
EMERGENCY

Wherever this Subpart conditions eligibility for placement on the interim provider list upon the applicant's having attained a specified level of supervised experience of any type (Sections 1905.50(b) and (c) and 1905.70(b) of this Part), any qualifying experience attained after January 1, 2004 must have been directly supervised (in-room supervision) by a provider on the Board's interim provider list for the activities for which approval is sought by the applicant.

a) Notwithstanding a requirement for supervised experience, qualifying experience attained prior to January 1, 2004 need not have been supervised.

b) If the qualifying experience was attained outside of Illinois after January 1, 2004, the experience must have been supervised by a provider who would have been eligible for Board approval for the appropriate purpose if practicing in Illinois.

Section 1905.100 Application
EMERGENCY

A provider seeking placement on the interim approved provider list must complete and submit to the Board an application form provided by the Board that contains the elements prescribed in this Section and identifies the services for which the provider seeks approval. The elements of the application include:

a) provider identification, including name and business address, telephone number, fax number, and e-mail address;

b) a listing of the counties in which the applicant provides services;

c) a listing of any and all currently held licenses or certifications;

d) identification of any languages other than English in which the applicant is fluent and can provide services (optional);

e) the applicant's separate attestations that none of the bars to eligibility listed in Section 1905.40 of this Part apply;

f) separate attestations that the applicant meets each of the qualifications applicable to the type(s) of approval sought;

g) an agreement that the applicant will conduct sex offender evaluations and provide sex offender treatment in accordance with the requirements of Subpart D of this Part;

h) attestation that the applicant's placement on the interim provider list will expire no later than July 1, 2005;

i) attestation that the applicant's submission of false information will result in removal from the approved provider list; and

j) an agreement to notify the Board immediately if the provider becomes ineligible under Section 1905.40 of this Part.

Section 1905.110 Application Review and Approval
EMERGENCY

Submitted applications will be referred to an application review committee, appointed by the Board, for review and approval.

a) The committee will consist of no fewer than three members, including at least one sex offense specific treatment provider, one sex offense specific evaluator, and one victim advocate.

b) No committee member holding a personal or financial interest in an application before the committee shall participate in the deliberation or voting on approval of the application.

c) The committee shall review the application and, within 45 days after receipt of the application shall either:

1) if it appears to the committee that all requirements for the type of approval applied for are met, direct that the applicant's name be added to the interim approved provider list and notify the applicant or

2) if deficiencies are found in the application, notify the applicant of the deficiencies in writing. An application may be resubmitted after the deficiencies have been corrected.

Section 1905.120 Appeal of Application Denial
EMERGENCY

An applicant whose application for placement on the interim approved provider list is denied may appeal the decision of the application review committee by requesting review by the Board.

a) The request must be made in a writing that is received by the Board within 30 days after the denial was mailed to the business address supplied by the applicant.

b) The applicant must submit with the appeal all documentation necessary and available to support placement on the list.

c) Copies of the appeal, including supporting documentation, will be provided to each Board member, and the appeal shall be considered on the next regularly scheduled meeting of the Board held more than two weeks after receipt of the appeal.

d) The vote of the Board shall be final, and the Board will notify the applicant of the result within two weeks of the Board's action.

e) Individuals whose applications have been denied may re-apply at such time that the circumstances leading to the original denial of placement on the interim approved provider list have substantively changed.

Section 1905.130 Removal from Provider List
EMERGENCY

The Board may rescind its approval of a person on the interim approved provider list for any of the reasons listed below.

a) The provider was not, in fact, qualified for placement on the list at the time of application, but was placed on the list on the basis of false or erroneous information provided with the application.

b) Circumstances of the provider have changed such that the provider is no longer eligible for placement on the list under Section 1905.40 of this Part.

c) The provider has substantially failed to follow the agreement to conduct evaluations and provide treatment to sex offenders in accordance with the requirements of Subpart D of this Part. For purposes of this Section, a substantial failure is one that is detrimental to the patient or the community.

d) If such an action is taken, the Board will inform any regulatory body with jurisdiction over the provider's professional license, if any.

Section 1905.140 Complaints Against Providers
EMERGENCY

Should any person have reason to believe that the Board's approval of a provider should be rescinded, the person may submit the concern to the Board in writing together with any available documentation. Complaints will be reviewed in accordance with the procedure set forth in this Section.

a) The Board will refer the complaint to a committee it empowers for that purpose, and the committee will make a determination of whether the complaint alleges cause to rescind approval under Section 1905.130 of this Part. The Board will notify the provider in question of receipt of a complaint and its nature and, if the complaint does allege cause to rescind, will request a written response from the provider within 30 days of receipt of the notice.

b) The committee shall review all information presented and determine whether the provider shall remain approved or whether approval shall be rescinded, and provide written notification of the decision, including the rationale, to the provider and the complainant within 30 days of the committee's receipt of the provider's response or, if there is no response, within 30 days of the committee's notification to the provider.

c) If the committee rescinds approval, it shall instruct the provider as to the circumstances under which the provider may be reinstated.

d) For 35 days after the committee notifies the provider, the provider may appeal to the Board the decision of the subcommittee to rescind approval. On appeal, the pertinent documentation shall be provided to the full Board for review at the next regularly scheduled meeting of the Board held more than 30 days after receipt of the appeal. The provider shall have an opportunity to appear before the Board with respect to the appeal or, if unable to attend the meeting at which the matter is to be considered, to submit a statement to the Board. The provider shall be notified in writing of the decision of the Board within 30 days after Board consideration is complete.

e) The decision of the full Board shall be final.

Section 1905.200 Scope
EMERGENCY

This Subpart prescribes interim standards for the conduct of evaluations of, and the provision of treatment to, sex offenders in whatever circumstances require that the services be provided in accordance with standards adopted by the Board under the Act.

Section 1905.210 Ethical Standards
EMERGENCY

All providers of sex offender evaluations or treatment under this Part are to adhere to the Code of Ethics (2001 Edition) published by the Association for the Treatment of Sexual Abusers (ATSA) (4900 S.W. Griffith Drive, Suite 274, Beaverton, Oregon 97005; Web: www.atsa.com). A copy of the Code is available at the office of the Chair of the Board (in the Office of the Attorney General, 100 W. Randolph St., 11th Floor, Chicago, Illinois 60601) or on the Board's Web site at http://www.illinoisattorneygeneral.gov/communities/somb. This incorporation by reference does not include any later amendments or editions.

Section 1905.220 Release of Information and Confidentiality
EMERGENCY

a) Prior to evaluating or accepting a sex offender into treatment, the provider shall obtain from, and with the informed consent of, the offender a signed release that, subject to the Mental Health and Developmental Disabilities Confidentiality Act [740 ILCS 110], allows the provider to share the offender's confidential information with:

1) all therapists treating the sex offender;

2) when indicated, the victim's therapist;

3) the supervising officer and all members of the team and, if applicable, to the Department of Human Services and other individuals or agencies responsible for the supervision of the sex offender;

4) when indicated, the victim or custodial parent or guardian of a child victim, particularly with regard to family reunification or the sex offender's compliance with treatment and information about risk, threats, and possible escalation of violence; and

5) when indicated, the victim's guardian ad litem, advocate, guardian, caseworker or other professional involved in care or treatment of the victim regarding reunification of the family or contact with past or potential child victims.

b) Information received pursuant to a release under this Section shall be kept confidential except to the extent the release allows the information to be shared.

c) A provider shall notify all clients of the limits of confidentiality imposed on therapists by the Abused and Neglected Child Reporting Act [325 ILCS 5].

d) A provider shall ensure that a sex offender understands the scope and limits of confidentiality in the context of his/her particular situation, including the collection of collateral information, which may or may not be confidential.

Section 1905.230 General Standards for Conducting Evaluations
EMERGENCY

a) Sex offender evaluations are to be comprehensive and sex offense-specific. They are to be designed to achieve the following purposes:

1) To document the offense-specific and/or mental health treatment needs identified by the evaluation (even if resources are not available to address adequately the treatment needs of the sexually abusive offender);

2) To provide a written clinical evaluation of a sex offender's risk for re-offending and current amenability to treatment;

3) To guide and direct specific recommendations for the conditions of treatment and supervision of a sex offender;

4) To provide information that will help to identify the optimal setting, intensity of intervention, and level of supervision; and

5) To provide information that will help to identify sex offenders who should not be referred for community-based treatment.

b) The evaluator must obtain the offender's informed assent to the evaluation and shall inform the offender regarding the evaluation methods, how the information will be used, and to whom it will be given. The evaluator shall respect a sex offender's right to be fully informed about the evaluation procedures. Results of the evaluation should be shared with the sex offender and any questions clarified.

c) The evaluator shall be sensitive to any cultural, ethnic, developmental, sexual orientation, gender, medical and/or educational issues that may arise during the evaluation.

d) Evaluations shall include:

1) Examination of criminal justice information, including prior juvenile adjudications, the details of the current offense and documents that describe victim trauma, when available.

2) Examination of collateral information, including information from other sources on the sex offender's sexual behavior.

3) Review of child welfare investigations and case records, where applicable.

e) In the case of a pre-sentence evaluation, the evaluator (if different from the treatment provider) shall provide complete information obtained in the course of the evaluation to the containment team or prison treatment provider at the beginning of the sex offender's term of supervision or incarceration.

Section 1905.240 Elements of Comprehensive Sex Offense Specific Evaluations EMERGENCY

Pre-sentence evaluations must include the following elements using one or more of the listed possible evaluation procedures as clinically indicated:

a) Evaluation of mental and/or organic disorders, including the areas of

1) IQ functioning (developmental disability, learning disability, and literacy), using history or functioning and/or standardized tests, examples of which include:

A) tests of non-verbal intelligence such as WAIS-III, WRAT-R, Revised Beta, TONI (tests of non-verbal intelligence)

B) Shipley Institute of Living Scale Revised, Kaufman IQ Test for Adults

2) Organic Brain Syndrome (OBS), using history or functioning and/or standardized tests (Examples: WAIS-III, Weschler Memory Scale Revised, Limbic System Checklist, Structured Mental Status, Jacobs Cognitive Screening Test, medical tests necessary for diagnosis)

3) Mental illness, using:

A) History of Functioning and/or Structured Interview

B) MMPI2

C) MCMI-III

D) Beck Depression Scale

b) Evaluation of drug/alcohol use, including the areas of:

1) Use/abuse, using:

A) History of functioning and/or structured interview

B) MMPI2

C) CAQ (clinical analysis questionnaire)

D) PHQ (personal history questionnaire)

E) ADS

F) DAST-20

G) Adult substance use survey

H) Substance use history matrix

I) Collateral information

2) Number of relapses, using:

A) History of functioning and/or structured interview

B) Treatment history

C) Collateral information

c) Evaluation of degree of psychopathology, in particular the degree of impairment, using:

1) Hare Psychopathy Checklist Revised (PCLR or PCLSC)

2) Structured interview

3) MCMI-III

4) MMPI2

5) History

6) Collateral information

d) Evaluation of stability of functioning, including the areas of:

1) Marital/family stability,

A) covering:

i) Past

ii) Current

iii) Familial violence

iv) Familial sexual

v) Financial

vi) Housing

B) using:

i) History of functioning and/or structured interview

ii) FES (Family Environment Scale)

iii) DAS (Dyadic Adjustment Scale)

iv) MSI (Marital Satisfaction Inventory)

v) SARA (Spousal Assault Risk Assessment)

vi) Interview attitudes

vii) Collateral information

2) Employment/education - Completion of Major Life Tasks, using:

A) History of Functioning and/or Structured Interview

B) PHQ (Personal History Questionnaire)

3) Social skills,

A) covering:

i) Ability to form relationships

ii) Ability to maintain relationships

iii) Courtship/dating skills

iv) Ability to demonstrate assertive behavior

B) using:

i) History of functioning and/or structured interview

ii) Collateral information

iii) IBS (interpersonal behavior survey)

iv) Social Avoidance and Distress Scale

v) Waring's Intimacy Scale

vi) UCLA Loneliness Scale

vii) Tesch's Intimacy Scale

viii) Miller's Social Intimacy Scale

e) Evaluation of developmental history,

1) covering:

A) Disruptions in parent/child relationship

B) History of bed wetting, cruelty to animals

C) History of behavior problems in elementary school

D) History of special education services, learning disabilities, school achievement

E) Indicators of disordered attachments

2) using:

A) History of functioning and/or structured interview

B) Collateral Information

f) Evaluation of self-image and self-esteem, using:

1) History of functioning and/or structured interview

2) MPD (measures of psychological development)

3) CAQ (clinical analysis questionnaire)

4) CPI (California Personality Inventory)

g) Evaluation of medical screening measures,

1) covering:

A) Pharmacological needs

B) Medical condition impacting offending behavior

C) History of medication use/abuse

2) using:

A) History of functioning and/or structured interview

B) Referral to physician if indicated

C) Medical tests

h) Sexual Evaluation, including the areas of:

1) Sexual history (onset, intensity, duration, pleasure derived),

A) covering:

i) Age of onset of expected normal behaviors

ii) Quality of first sexual experience

iii) Age of onset of deviant behavior

iv) Witnessed or experienced victimization (sexual or physical)

v) Genesis of sexual information

vi) Age/degree of use of pornography, phone, cable, video, or internet for sexual purposes

vii) Current and past range of sexual behavior

B) using:

i) History of functioning and/or structured interview

ii) PSCI (Personal Sentence Completion Inventory – Miccio-Fonseca)

iii) Wilson Sexual Fantasy Questionnaire

iv) SONE Sexual History Background Form

v) SORI (Sex Offender Risk Instrument – in research stage)

vi) Collateral information

2) Reinforcement structure for deviant behavior,

A) covering:

i) Culture

ii) Environment

iii) Cults

iv) Gangs

B) using structured interview

3) Arousal pattern,

A) covering:

i) Sexual arousal

ii) Sexual interest

B) using:

i) Structured interview

ii) Sexual autobiography

iii) Plethysmography

iv) Abel Assessment for Sexual Interest

v) Collateral information (such as from spouses or significant others)

4) Specifics of Sexual Crime(s) (onset, intensity, duration, pleasure derived),

A) covering:

i) Detailed description of sexual assault

ii) Seriousness, harm to victim

iii) Mood during assault (anger, erotic, "love")

iv) Progression of sexual crimes

v) Thoughts preceding and following crimes

vi) Fantasies preceding and following crimes

B) using:

i) Structured interview

ii) History of crimes

iii) Review of criminal records

iv) Contact with victim therapist

v) Polygraph

vi) Collateral information

5) Sexual deviance, using:

A) Structured Interview

B) MSI (Multiphasic Sex Inventory)

C) SONE

6) Dysfunction,

A) covering:

i) Impotence

ii) Priapism

iii) Injuries

iv) Medications affecting sexual functioning, etc.

B) using:

i) Structured interview

ii) MSI (Multiphasic Sex Inventory)

iii) Sexual autobiography

7) Sex offender's perception of dysfunction, using:

A) Structured interview

B) Sexual autobiography

C) Bentler Heterosexual Inventory

D) History

8) Perception of sexual functioning, using:

A) Structured interview

B) Sexual autobiography

C) Plethysmography

D) Bentler Sexual Behavior Inventory

9) Preferences,

A) covering:

i) Male/female

ii) Age

iii) Masturbation

iv) Use of tools

v) Utensils

vi) Food

vii) Clothing

viii) Current sexual practices

ix) Deviant as well as normal behavior

B) using:

i) Structured interview

ii) Sexual autobiography

iii) Plethysmography

iv) Abel Assessment for Sexual Interest

v) Collateral information (such as from spouses or significant others)

10) Attitudes/cognition,

A) covering:

i) Motivation to change/continue behavior

ii) Attitudes toward women, children

iii) Sexuality in general

iv) Attitudes about offenses (i.e., seriousness, harm to victim)

v) Degree of victim empathy

vi) Presence/degree of minimalization

vii) Presence/degree of denial

viii) Ego-syntonic vs. ego-dystonic sense of deviant behavior

B) using:

i) Structured interview

ii) Burt Rape Myth Acceptance Scale

iii) MSI (Multiphasic Sex Inventory)

iv) Buss/Durkee Hostility Inventory

v) Abel and Becker Cognitions Scale

vi) Attitudes Towards Women Scale

vii) Socio-Sexual Knowledge and Attitudes Test (for use with sex offenders who have developmental disabilities)

i) Evaluation of level of denial and level of deception, using

1) Structured interview

2) Polygraph

3) Collateral Information (such as from victim, police, others)

j) Evaluation of level of violence and coercion,

1) covering:

A) Level of violence

B) Overall pattern of assaultiveness

C) Victim selection

D) Pattern of escalation of violence

2) using:

A) Structured interview

B) History

C) Review of criminal records

D) Collateral information

k) Evaluation of risk of re-offense, using:

1) Criminal history

2) Violence Risk Assessment Guide (normed on a psychiatric hospital sample) (good predictor of violence recidivism but not of sexual recidivism)

3) Rapid Risk Assessment for Sex Offender Re-Arrest (sample excludes incest offenders)

4) MnSOST-R (normed on Minnesota Offenders in the Department of Corrections, excludes incest offenders)

5) Static 99

6) SONAR

7) Any other validated risk instrument that is generally accepted by sex offender evaluators

Section 1905.250 Evaluator Recommendations
EMERGENCY

a) The evaluator shall consider the following factors when making recommendations relating to a sex offender's risk to re-offend and amenability to treatment:

1) Admission of offenses;

2) Accountability (internal and external factors which control behavior);

3) Cooperation;

4) Offense history and victim choice;

5) Escalating pattern of offenses, violence, and dangerous behaviors;

6) Sexual deviance, arousal patterns, and sexual interest;

7) Social interest;

8) Lifestyle characteristics;

9) Psychopathology;

10) Developmental markers;

11) History of childhood or adolescent delinquency;

12) Substance abuse;

13) Criminal history;

14) Social support systems;

15) Overall control and intervention;

16) Motivation for treatment and recovery;

17) Self-structure;

18) Disowning behaviors;

19) Prior treatment;

20) Impact on victims;

21) Access to potential victims;

22) Availability of treatment in the community;

23) Availability of supervision, including surveillance agents, in the community.

b) The evaluator shall recommend:

1) The level and intensity of offense-specific treatment needs;

2) Referral for assessment and/or treatment of co-existing conditions (e.g., substance abuse, mental illness, medical/pharmacological);

3) Methods to lessen victim impact (e.g., no-contact orders, paying for counseling, involvement of non-offending spouse, etc.);

4) Appropriateness of community placement with emphasis on the risks associated with the home, neighborhood, school or community;

5) The level and intensity of behavioral monitoring needed;

6) The types of external controls which should be considered specifically for that sex offender (e.g., controls of work environment, access to children, leisure time, or transportation; life stresses; or other issues that might increase risk and require increased supervision);

Section 1905.300 General Standards for Treatment
EMERGENCY

a) Treatment of sex offenders must be sex offense specific.

b) A treatment provider shall develop a written treatment plan with measurable goals based on the needs and risks identified in current and past assessments or evaluations of the sex offender.

c) The treatment plan shall:

1) Provide for the protection of victims and potential victims and not cause the victims to have unsafe or unwanted contact with the sex offender;

2) Be individualized to meet the unique needs of the sex offender;

3) Identify

i) the issues to be addressed, including multi-generational issues if indicated,

ii) the planned intervention strategies,

iii) and the goals of treatment;

4) Define expectations of the sex offender, his/her family (when possible), and support systems;

5) Address the issue of ongoing victim input;

6) Describe the treatment provider's role in implementing the treatment plan.

d) A provider shall submit written quarterly progress reports to the referral source

e) A provider shall employ treatment methods that are supported by current professional research and practice. Group therapy (with the group comprised only of sex offenders) is the preferred method of treatment. At a minimum, any method of psychological treatment used must conform to the standards for content of treatment and must contribute to behavioral monitoring of sex offenders. The sole use of individual therapy is not recommended with sex offenders and shall be avoided except when geographical (specifically rural) or disability limitations dictate its use or when it is clinically indicated. While group therapy is the preferred modality, individual therapy may be an appropriate adjunct treatment.

1) The use of male and female co-therapists in group therapy is highly recommended and may be required by the supervising agency.

2) The ratio of therapists to sex offenders in a treatment group shall not exceed 1:10

3) Treatment group size shall not exceed 12 sex offenders.

4) The provider shall employ treatment methods that give priority to the safety of the sex offender's victims and the safety of potential victims and the community.

5) The provider shall employ treatment methods that are based on recognition of the need for long-term, offense-specific treatment for sex offenders. Self-help or time-limited treatment shall be used only as adjuncts to long-term, comprehensive treatment.

f) Sex offender-specific treatment may also be supplemented with treatment for drug/alcohol abuse, marital therapy, and/or crisis intervention services.

g) In order to achieve the goals of sex offense specific treatment, the following elements shall be addressed in treatment:

1) Offense Disclosure: The sex offender discloses all of his or her sexual offenses, reducing denial and defensiveness and/or assisting the sex offender in assuming full responsibility for his or her sexual offending. Completion indicators:

A) The sex offender makes a disclosure of all sex offenses.

B) The sex offender attends treatment sessions as ordered or required.

C) The sex offender completes all assigned tasks as required.

D) When available, the sex offender completes non-deceptive polygraphs on past and maintenance issues.

E) The sex offender consistently takes full responsibility for all of his or her actions including sex offenses, as indicated by polygraph.

F) The sex offender holds himself/herself accountable for his/her behavior in general.

2) Offense-Specific Cognitive Restructuring: Cognitive distortions refer to distortions in thinking, including thinking errors that enable sexually

offending behaviors. Identifying and correcting or changing sex offenders' cognitive distortions that fuel sexual offending is the purpose of this element of treatment.
Completion indicators:

A) The sex offender identifies and restructures offense-specific cognitive distortions.

B) The sex offender assumes responsibility for offending.

C) There is evidence that offense-specific distortions have been restructured or changed as indicated by the lack of using cognitive distortions and that the sex offender holds self fully accountable when discussing the offenses.

3) Assault Cycle and Intervention: The assault cycle comprises the repetitive patterns of sexual offending. This element of treatment is intended to: identify the sex offender's patterns of offending, including risk factors; teach sex offenders self-management methods, skills, and appropriate coping skills to eliminate a sexual re-offense; educate sex offenders and individuals who are identified as the sex offender's support system and the containment team about the potential for re-offending and the sex offender's specific risk factors; and require sex offenders to learn specific relapse prevention strategies, including the development of a written, specific relapse prevention plan, which should identify antecedent thoughts, feelings, situations, social behaviors, and any other behaviors associated with sexual offenses along with specific interventions.
Completion indicators:

A) The sex offender demonstrates identification of his/her own assault cycle and how he/she applies it to his/her daily lifestyle.

B) The sex offender demonstrates knowledge of relapse intervention concepts.

C) The sex offender has consistently demonstrated the effective use of relapse prevention skills, i.e., is able to diffuse cycle behaviors, relapse processes, deviant arousal and other factors that contribute to sexual offending.

D) The sex offender has disengaged from relationships that support his or her denial, minimization, and resistance to treatment.

E) The sex offender is engaged in relationships that are supportive of treatment and seeks feedback from his/her support system.

F) The sex offender has demonstrated consistently the ability to avoid high-risk environments.

4) Victim Empathy: Empathy is the capacity to understand and identify with another's perspective and experience the same emotions. The ability to develop victim empathy may vary from sex offender to sex offender and may have varying emphasis in treatment.
Completion indicators:

A) The sex offender verbalizes and demonstrates victim empathy, identifies feelings, recognizes victim impact, assumes ownership of offenses, understands and takes the perspective of others, demonstrates emotional regret, and expresses feelings of empathy and remorse.

B) The sex offender demonstrates behaviors that indicate reduced risk of harm to victims.

C) Cautionary Note: TREATMENT TO ASSIST IN THE DEVELOPMENT OF VICTIM EMPATHY IS CONTRAINDICATED FOR PSYCHOPATHIC OFFENDERS.

5) Arousal Control: This element of treatment is intended to assess, identify, and decrease or replace deviant sexual desires, arousal, thoughts, and fantasies, replacing this deviancy with healthier sexual attitudes and functioning.
Completion indicators:

A) The sex offender discloses deviant and/or violent sexual fantasies.

B) The frequency and intensity of deviant arousal, violent and/or sadistic fantasies, and masturbation to deviant fantasies are decreased.

C) The sex offender develops behavioral/self management strategies to reduce deviant arousal and behavior patterns, including eliminating self-abusive sexual behaviors.

D) The sex offender develops and maintains normal, non-victimizing fantasies.

6) Clinical/Core Issue Resolution: It is commonly assumed that offending involves multiple unresolved emotional issues and not just deviant sexual urges. Motivational dynamics that may fuel sexual offending or other

victimizing or assaultive behaviors may arise from the effects of trauma or past victimization, key developmental events, or other unresolved problems or needs. It is critical for resolution of these core issues to occur without the sex offender assuming a victim stance. Sex offenders must still be held accountable for their offending when these issues are resolved.
Completion indicators:

A) The sex offender has identified and resolved or mostly resolved core issues that may facilitate sexual re-offense. Core issues may include anger, power, control, inferiorities, dependency, insecurity, rejection, jealousy, possessiveness, resentment, and inadequacies in terms of self-worth and self-esteem.

B) The sex offender has identified and changed the effects of past trauma and past victimizations to decrease their impact on the risks of re-offending.

7) Social Skills and Interpersonal Restructuring: Social skills refer to specific communication skills and social behaviors. Interpersonal restructuring refers to redefining the way sex offenders form attachments or relate to others. Interpersonal deficits are frequently associated with attachment issues. The development of basic social skills replaces deficits and inappropriate attachments or relationships, diminishing the risk of sexual re-offending. This element of treatment is intended to: identify deficits in specific interpersonal skills and decrease the sex offender's deficits in social and relationship skills, where applicable; and assist sex offenders in developing and practicing social skills, improving the quality of their relationships with others.
Completion indicators:

A) Demonstrates appropriate social relationships.

B) Demonstrates appropriate boundaries.

C) Has the skills to manage interpersonal relationship issues.

8) Lifestyle Balancing and Restructuring: Lifestyle balancing and restructuring refers to assisting sex offenders in changing their existing lifestyles to lifestyle patterns that minimize sexual re-offending and maintaining this lifestyle. The focus of this element of treatment is to: educate sex offenders about non-abusive, adaptive, legal, and pro-social sexual functioning; identify and treat sex offenders' personality traits, lifestyle, behaviors, patterns, and deficits that are related to their potential for re-offending; and maximize opportunities for the sex offender to

develop a healthy self-esteem.
Completion indicators will demonstrate a change in personality traits, lifestyle behaviors, patterns, and deficits related to the potential for re-offending including:

A) Antisocial/psychopathic behaviors.

B) Narcissistic behaviors.

C) Borderline characteristics of behavior.

D) Schizoid behaviors.

E) Obsessive-compulsive/passive-aggressive behaviors.

F) Demonstrates a healthy and balanced lifestyle.

9) The provision of treatment referrals, as indicated, links sex offenders with other resources such as medical, pharmacological, mental, substance abuse, and/or domestic violence services.
Completion indicators:

A) Monitoring sex offenders' linkage with other referral resources.

B) Communication with others. Communication is a critical element in treatment, aftercare and supervision. This element of treatment maintains communication with significant persons in sex offenders' support systems, when indicated, and to the extent possible to assist in meeting treatment goals.

h) Providers shall maintain sex offenders' files in accordance with the professional standards of their individual disciplines. The files shall:

1) Document the goals of treatment, the methods used, and the sex offender's observed progress, or lack thereof, toward reaching the goals in the treatment records. Specific achievements, failed assignments, rule violations, and consequences given should be recorded.

2) Accurately reflect the sex offender's treatment progress, sessions attended, and changes in treatment.

Section 1905.310 Treatment Provider Client Written Treatment Agreement EMERGENCY

a) Prior to treatment and as a condition of treatment, a provider shall enter into a written contract with the sex offender prior to the commencement of treatment. The contract shall describe the responsibilities of both the provider and the sex offender. Breech of the contract by the offender may serve as the basis for revocation of probation or, a recommendation to the Prisoner Review Board to revoke parole or other community supervision.

b) The contract shall describe the role of the treatment provider in implementing the treatment plan as well as the responsibility of the provider to:

1) Define and provide timely statements of the costs of the assessment, evaluation, and treatment, including all medical and psychological tests, physiological tests, and consultations;

2) Describe the releases of information that will be required for a provider to treat the sex offender for his/her sexual offending behavior, describe the various parties with whom treatment information will be shared during the treatment, describe the time limits on the releases, and describe the procedures necessary for the sex offender to revoke the releases;

3) Describe the right of the sex offender to refuse treatment and/or to refuse to sign a release, and describe the risks and potential risks and outcomes of that decision;

4) Describe the type, frequency, and requirements of the treatment and outline how the duration of treatment will be determined;

5) Describe the limits of confidentiality imposed on the therapist by the mandatory reporting law.

c) The contract shall describe the responsibilities of the sex offender (as applicable) to:

1) Pay for the cost of evaluation and treatment for self, and to his or her family, if applicable;

2) Pay for the cost of evaluation and treatment for the victims and their families, when ordered by the court, including all medical and psychological tests, physiological testing, and consultation;

3) Inform the treatment provider, the sex offender's immediate family, and

support system of the details of all past sexual offenses to ensure help and protection for past victims and/or as relevant to the development of the relapse prevention plan. Clinical judgment should be exercised in determining what information is provided to children;

4) Actively involve members of the sex offender's family and support system, as indicated in the relapse prevention plan;

5) Notify the treatment provider of any changes or events in the lives of the sex offender, the members of the sex offender's family, or support system;

6) Comply with the limitations and restrictions placed on the behavior of the sex offender, as described in the terms and conditions of probation, parole, or conditional release for sexually violent persons or sexually dangerous persons and/or in the contract between the provider and the sex offender.

d) The contract shall describe the responsibility of and restrictions on the sex offender to protect community safety by avoiding risky, aggressive, or re-offending behavior by avoiding high-risk situations, and by reporting any such behavior to the provider and supervising officer as soon as possible.

e) The contract shall describe the responsibility of the provider to:

1) Identify, and provide timely statements of, the costs of assessment, evaluation, and treatment, including all medical and psychological tests, physiological tests, and consultations, to the sex offender as well as the parent or guardian.

2) Describe the information releases that will be required for a provider to treat the sex offender for his/her sexual offending behavior; describe the various parties with whom treatment information will be shared during the treatment; describe the time limits on the waivers of confidentiality; and describe the procedures necessary for the sex offender to revoke the waiver.

3) Describe the right of the sex offender to refuse treatment and/or to refuse to consent to disclosure, and describe the consequences, risks and potential risks and outcomes of that decision, including the provider's right not to provide treatment if the necessary releases are not given.

4) Describe the type, frequency, and requirements of the treatment and outline how the duration of treatment will be determined.

5) Describe the limits of confidentiality imposed on the therapist by the mandatory reporting law.

f) The provider shall explain the terms of the contract to the sex offender in language that the sex offender understands.

Section 1905.320 Completion of Treatment
EMERGENCY

a) Completion of treatment should be understood as meaning the successful completion of treatment, and not as the cessation of court-ordered, offense-specific treatment or the completion of the sentence imposed by the court or the Prisoner Review Board. Successful completion of treatment may not end the sex offender's need for ongoing rehabilitation or elimination of risk to the community. If risk increases, treatment may be re-instated upon the request of the sex offender or the recommendation of the containment team. Treatment should be viewed as ranging from intensive to aftercare.

b) The sex offender containment team shall consult about the completion of treatment. The decision shall come after the evaluation and assessment, treatment plan, course of treatment sequence, and a minimum of a non-deceptive disclosure polygraph examination and two or more non-deceptive maintenance polygraph examinations, regarding compliance with court rules, compliance with supervision conditions, compliance with treatment contract provisions, including complete abstinence from grooming (i.e., manipulation intended to reduce victims' defenses) of victims, or potential victims, and full, voluntary compliance with all conditions required to prevent re-offending behavior. The two or more non-deceptive polygraph examinations must be those most recent prior to termination of treatment. (See definitions for non-deceptive polygraph results.) A failed polygraph examination should not be used as the sole reason to deny successful completion of treatment. The team should carefully consider termination of treatment based on maintaining community safety.

c) Those sex offenders who pose an ongoing threat to the community require supervision, even while demonstrating progress in treatment, and may require ongoing supervision and treatment to manage their risk, including revocation as authorized and approved in writing by the Prisoner Review Board when on parole. Any exception made to any of the requirements for treatment completion must be made by the consensus of the containment team. In this case, the team must document the reasons for the determination that treatment completion is appropriate without meeting all of the standard requirements and note the potential risk to the community.

d) To determine the recommendations for the termination of treatment, the provider shall:

1) Assess actual changes in a sex offender's potential to re-offend prior to recommending treatment termination;

2) Attempt to repeat, where indicated, those evaluations that might show

changes in the sex offender;

3) Assess and document how the goals of the treatment plan have been met, what actual changes in a sex offender's re-offense potential have been accomplished, and what risk factors remain, particularly those affecting the emotional and physical safety of the victims;

4) Seek input from others who are aware of a sex offender's progress as part of the decision about whether to terminate treatment;

5) Report to the supervising officer regarding a sex offender's compliance with treatment and recommend any modifications in conditions of community supervision and/or termination of treatment; and

6) At the end of this evaluation process, inform the sex offender regarding the recommendation to end or continue court-ordered treatment.

e) Prior to terminating offense-specific treatment, a provider shall, in cooperation with the containment team, develop an aftercare plan that includes ongoing behavioral monitoring, such as periodic polygraph examinations. Such monitoring is intended to motivate the sex offender to avoid high-risk behaviors that might be related to increased risks of re-offense.